FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004820

Facility Name: VALLEY HI NURSING HOME

Address: 2406 Hartland Road (Number) Woodstock (City) 60098 (Zip Code)

County: McHenry

Telephone Number: (815) 338-0312 **Fax #** (815) 338-0458

IDPA ID Number: 36-6006623

Date of Initial License for Current Owners: 1/1/56

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/99 to 11/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANT'S REPORT ATTACHED	(Date)
	(Print Name and Title) Marvin Fox, CPA	
	(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015	
	(Telephone) (847) 236-1111	Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,502	1
2		Skilled Pediatric (SNF/PED)			2
3	20	Intermediate (ICF)	20	7,320	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	117	42,822	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,401	3,140	1,837	23,378	8
9	SNF/PED					9
10	ICF	12,164		659	12,823	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,565	3,140	2,496	36,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.54%

D. How many bed-hold days during this year were paid by Public Aid? 694 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/56

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,173

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/00 Fiscal Year: 11/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	256,253	25,174	11,388	292,815		292,815	(3,190)	289,625			1
2	Food Purchase		177,119		177,119		177,119	(154)	176,965			2
3	Housekeeping	165,391	36,326		201,717		201,717		201,717			3
4	Laundry	91,682	19,434	26,773	137,889		137,889		137,889			4
5	Heat and Other Utilities			131,244	131,244		131,244		131,244			5
6	Maintenance	67,630	550	103,511	171,691		171,691	(7,200)	164,491			6
7	Other (specify):*											7
8	**TOTAL General Services**	580,956	258,603	272,916	1,112,475		1,112,475	(10,544)	1,101,931			8
	B. Health Care and Programs											
9	Medical Director			900	900		900		900			9
10	Nursing and Medical Records	2,040,374	73,175	300,153	2,413,702		2,413,702		2,413,702			10
10a	Therapy	112,283	37	21,103	133,423		133,423		133,423			10a
11	Activities	92,018	1,727	2,889	96,634		96,634		96,634			11
12	Social Services	32,604		12,962	45,566		45,566		45,566			12
13	Nurse Aide Training	12,460	47	6,947	19,454		19,454		19,454			13
14	Program Transportation			175	175		175		175			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,289,739	74,986	345,129	2,709,854		2,709,854		2,709,854			16
	C. General Administration											
17	Administrative	124,775			124,775		124,775		124,775			17
18	Directors Fees											18
19	Professional Services			24,968	24,968		24,968	7,841	32,809			19
20	Dues, Fees, Subscriptions & Promotions			63,953	63,953		63,953	(288)	63,665			20
21	Clerical & General Office Expenses	115,584	12,077	31,272	158,933		158,933	14,385	173,318			21
22	Employee Benefits & Payroll Taxes			853,968	853,968		853,968		853,968			22
23	Inservice Training & Education			2,943	2,943		2,943		2,943			23
24	Travel and Seminar			5,444	5,444		5,444	(712)	4,732			24
25	Other Admin. Staff Transportation			1,934	1,934		1,934		1,934			25
26	Insurance-Prop.Liab.Malpractice			70,841	70,841		70,841		70,841			26
27	Other (specify):*											27
28	**TOTAL General Administration**	240,359	12,077	1,055,323	1,307,759		1,307,759	21,226	1,328,985			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,111,054	345,666	1,673,368	5,130,088		5,130,088	10,682	5,140,770			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

VALLEY HI NURSING HOME
0004820
COST REPORT RECLASSIFICATIONS
12/01/99
11/30/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		
2		FOOD	

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19		PROFESSIONAL FEES	

To reclass cost of appealing real estate taxes

Facility Name & ID Number VALLEY HI NURSING HOME #0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			288,916	288,916		288,916	(2,972)	285,944			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							38,402	38,402			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			288,916	288,916		288,916	35,430	324,346			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,339	41,280	105,619		105,619		105,619			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,233	64,233		64,233		64,233			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		64,339	105,513	169,852		169,852		169,852			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,111,054	410,005	2,067,797	5,588,856		5,588,856	46,112	5,634,968			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,190)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,897)	30		9
10	Interest and Other Investment Income	(4,119)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,571)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(288)	20		28
29	Other-Attach Schedule	(9,030)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,249)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	69,361		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 69,361		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 46,112		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

VALLEY HI NURSING HOME

ID# 0004820

Report Period Beginning: 12/01/99

Ending: 11/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Out of State Seminars	(712)	24	2
3	Offset House Rental Expense Against Income	(7,200)	6	3
4	Out of Period Legal Expenses	(949)	19	4
5	Copy Income	(89)	21	5
6	Key Replacement	(5)	21	6
7	Polling Place Rental	(75)	30	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(9,030)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS	
	A. General Services												(to Sch V, col.7)	
1	Dietary	(3,190)											(3,190)	1
2	Food Purchase	(154)											(154)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(7,200)											(7,200)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(10,544)											(10,544)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(949)	8,790										7,841	19
20	Fees, Subscriptions & Promotions	(288)											(288)	20
21	Clerical & General Office Expenses	(3,665)	18,050										14,385	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(712)											(712)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(5,614)	26,840										21,226	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,158)	26,840										10,682	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 **Report Period Beginning:** 12/01/99 **Ending:** 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(2,972)											(2,972)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,119)	42,521										38,402	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(7,091)	42,521										35,430	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,249)	69,361										46,112	45

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		None		McHenry County	Woodstock, IL	County Gov't

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting	$	McHenry County	100.00%	$ 8,790	$ 8,790	1
2	V	21	Computer Services		McHenry County	100.00%	10,277	10,277	2
3	V	21	Data Processing		McHenry County	100.00%	7,773	7,773	3
4	V	32	Depreciation		McHenry County	100.00%	42,521	42,521	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 69,361	$ * 69,361	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V						$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: McHenry County Government Center
Street Address: 2200 N. Seminary Avenue
City / State / Zip Code: Woodstock, IL 60098
Phone Number: ((815) 338-2040
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2		Data available from McHenry County upon request.								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bond Series		X	Adv. Refunding of Existing Deb	Annual	8/12/98	$ 797,635	$	12/01/03	8.7%	$ 48,533	1
2												2
3	Interest allocated from											3
4	McHenry County											4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 797,635	$			$ 48,533	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	Interest Income										(4,119)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,119)	14
15	TOTALS (line 9+line14)						$ 797,635	$			$ 44,414	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	None	8
1996	None	9
1997	None	10
1998	None	11
1999	None	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,328 B. General Construction Type: Exterior Brick Frame Steel Number of Stories -

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Farm

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	435,600	1884	$ 6,000	1
2					2
3	TOTALS	435,600		$ 6,000	3

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97		1959	1959	$ 323,178	$ 0	40	$ 0	$	$ 323,178	4
5			1971	1971	528,627	0	42	0		528,627	5
6	20		1985	1985	1,819,573	50,471	36	50,471		1,019,568	6
7											7
8											8
	Improvement Type**										
9	Various			1971	4,812		20			4,812	9
10	Various			1972	11,001		20			10,969	10
11	Various			1973	7,293		20			7,293	11
12	Various			1974	4,623		20			4,623	12
13	Various			1975	12,023	19	20	19		12,023	13
14	Various			1976	2,020		20			2,020	14
15	Various			1979	13,489		20			13,489	15
16	Various			1980	5,630	116	20	116		5,045	16
17	Various			1981	9,718	339	20	339		9,376	17
18	Various			1983	3,913	131	20	131		3,577	18
19	Various			1984	20,296	320	20	320		15,635	19
20	Various			1985	6,129	197	20	197		5,248	20
21	Various			1986	19,490	780	20	780		11,307	21
22	Various			1987	220,215	10,234	20	10,234		144,187	22
23	Various			1988	78,309	3,127	20	3,127		54,359	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				49,751	1,127		1,127		1,690	34
35	PAGE 12A TOTALS				2,072,402	170,417		167,445	(2,972)	1,089,909	35
36	TOTAL (lines 4 thru 35)				$ 5,212,492	$ 237,278		$ 234,306	$ (2,972)	$ 3,266,935	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	671,552	33,470	20	33,532	62	366,663	9
10	Various			1990	226,997	14,772	20	14,772		159,925	10
11	Various			1991	36,994	2,981	20	2,981		28,636	11
12	Various			1992	37,992	3,437	20	3,437		31,769	12
13	Various			1993	22,729	942	20	942		22,070	13
14	Various			1994	28,719	7,062	20	4,028	(3,034)	26,181	14
15	Various			1995	30,212	2,124	20	2,124		17,016	15
16	FRONT DOORS-OVERHL			1996	275	28	20	28		124	16
17	WASTE WATER PROJ-ENG			1996	55,000	3,667	20	3,667		14,974	17
18	PAINTING			1996	631		20			631	18
19	CORNER GUARDS			1996	360	36	20	36		168	19
20	REWIRE FIRE DETECT.			1996	720	72	20	72		318	20
21	PAGING SYSTEM			1996	834	83	20	83		360	21
22	FRONT DOORS-OVERHL			1996	585	59	20	59		256	22
23	COOLING TOWER MOTOR			1996	602	30	20	30		130	23
24	CARPETING			1996	1,185	237	20	237		1,007	24
25	COMP SYS WIRE PROJ			1996	272,873	54,575	20	54,575		227,396	25
26	HANDRAILS			1996	4,202	280	20	280		1,167	26
27	PAGING SYSTEM			1996	569	57	20	57		233	27
28	PAGING SYSTEM			1996	423	42	20	42		206	28
29	WATER WASTE PROJECT			1996	640,585	42,706	20	42,706		174,383	29
30	PAINTING			1996	620		20			620	30
31	LIFE SAFETY UPGRADES			1996	25,845	2,585	20	2,585		11,848	31
32	BUILDING ALARM			1997	5,367	537	20	537		1,745	32
33	CLIMATE CONTROL COMP			1997	4,301	430	20	430		1,469	33
34	WATER HEATER VALVE			1997	1,883	188	20	188		580	34
35	MOTORS-HEAT PUMP			1997	347	17	20	17		34	35
36	TOTAL (lines 4 thru 35)				$ 2,072,402	$ 170,417		$ 167,445	$ (2,972)	$ 1,089,909	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FAUCETS			1998	842	42	20	42		84	9
10	HEAT PUMPS			1998	3,729	186	20	186		372	10
11	MOTORS-HEAT PUMP			1998	347	17	20	17		34	11
12	MOTORS-HEAT PUMP			1998	346	17	20	17		34	12
13	TRANSFER SWITCH			1998	749	37	20	37		74	13
14	GARBAGE DISPOSER			1998	1,050	53	20	53		106	14
15	TOILET BOWLS			1998	565	28	20	28		56	15
16	SIDEWALK			1998	903	45	20	45		90	16
17	2 EJECTOR PUMPS			1999	6,642	332	20	332		470	17
18	RETROFIT LIGHTING			2000	14,978	125	20	125		125	18
19	FIRE ALARM SYSTEM			2000	19,600	245	20	245		245	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 49,751	$ 1,127		$ 1,127	$	$ 1,690	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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14											14
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17											17
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 592,728	$ 38,633	$ 38,633	$		$ 404,824	37
38	Current Year Purchases	6,895	437	437			437	38
39	Fully Depreciated Assets	325,112	3,041	3,041			325,112	39
40								40
41	TOTALS	$ 924,735	$ 42,111	$ 42,111	$		$ 730,373	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Maintenance	Tractor	1985 & 1990	$ 12,351	$ 0	$ 0	$	10 & 5	$ 12,333	42
43	Facility	Chevy Corsica	1996	12,178	1,520	1,520		4	12,178	43
44	Facility	Ford Van	1999	40,035	8,007	8,007			14,012	44
45										45
46	TOTALS			$ 64,564	$ 9,527	$ 9,527	$		$ 38,523	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,207,791	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 288,916	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 285,944	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (2,897)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,035,831	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	1992 Crown Victoria	$ 12,000	$ 0	$ 12,000	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 12,000	$	$ 12,000	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

VALLEY HI NURSING HOME
0004820
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
11/30/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Valley Hi Nursing Home	592,728	38,633	38,633		404,824
TOTALS	592,728	38,633	38,633		404,824
LINE 29: CURRENT YEAR					
Valley Hi Nursing Home	6,895	437	437		437
TOTALS	6,895	437	437		437
LINE 30: FULLY DEPRECIATED					
Valley Hi Nursing Home	325,112	3,041	3,041		325,112
TOTALS	325,112	3,041	3,041		325,112
TOTALS (Should Tie to Totals on Page 13)					
Valley Hi Nursing Home	924,735	42,111	42,111		730,373
TOTALS	924,735	42,111	42,111		730,373

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 97

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 46

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 2,645	$ 4,302	$	$ 6,947
2	Books and Supplies		47		47
3	Classroom Wages (a)	962	11,498		12,460
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 3,607	$ 15,847	$	$ 19,454
10	SUM OF line 9, col. 1 and 2 (e)	$ 19,454			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 11,510

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	18

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 729	$		$ 729	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,052			3,052	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			24,296			24,296	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				38,511		38,511	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**					13,203	25,828		39,031	13
14	TOTAL			$		$ 41,280	$ 64,339		$ 105,619	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	17,859
4	Equipment Rental	2,479
5	Rental of Oxygen Concentrators	5,490
6		
7		
8		
9		
10		
		25,828

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2	Lab - Medicare	2,667
3	X-rays - Medicare	10,536
4		
5		
6		
7		
8		
9		
10		
		13,203

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 90,638	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	806,843		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,796		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 914,277	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,000		13
14	Buildings, at Historical Cost	5,020,615		14
15	Leasehold Improvements, at Historical Cos	182,774		15
16	Equipment, at Historical Cost	993,308		16
17	Accumulated Depreciation (book methods)	(3,841,167)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,361,530	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,275,807	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,799	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,650		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	87,117		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 328,566	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 328,566	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,947,241	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,275,807	$ #REF!	48

*(See instructions.)

Facility Name & ID Number VALLEY HI NURSING HOME **#** 0004820 **Report Period Beginning:** 12/01/99 **Ending:** 11/30/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 11/30/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		
Advanced Billing	59,363	
Resident Refund	7,319	
Bed Tax Liability	20,435	
	87,117	

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,102,224	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,102,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(154,983)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (154,983)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,947,241	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	VALLEY HI NURSING HOME	#	0004820	Report Period Beginning:	12/01/99	Ending:	11/30/00

Balance per General Ledger		3,102,224
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		3,102,224
Equity(Deficit) from Page 17 Col 1		2,947,241
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		2,947,241

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,818,391	1
2	Discounts and Allowances for all Levels	(1,079,771)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,738,620	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	43,943	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 43,943	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	11,510	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	78,560	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,852	19
20	Radiology and X-Ray	760	20
21	Other Medical Services	15,034	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 114,716	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,119	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,119	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	532,475	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 532,475	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,433,873	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,112,475	31
32	Health Care	2,709,854	32
33	General Administration	1,307,759	33
	B. Capital Expense		
34	Ownership	288,916	34
	C. Ancillary Expense		
35	Special Cost Centers	105,619	35
36	Provider Participation Fee	64,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,588,856	40
41	**Income before Income Taxes (line 30 minus line 40)****	(154,983)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (154,983)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Available If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 **Report Period Beginning:** 12/01/99 **Ending:** 11/30/00

SUPPLEMENTAL SCHEDULE OF REVENUES
11/30/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	Operating Transfer from Gen Fund	107,000
3	Operating Transfer from Social Security Fund	200,000
4	Operating Transfer from IMRF	200,000
5	Vending Machines/Pay Phones	9
6	Township Subsidy	18,097
7	Farm Income - House Rental	7,200
8	Copy Income (Adjusted off on Page 5)	89
9	Key Replacement (Adjusted off on Page 5)	5
10	Polling Room Rental (Adjusted off on Page 5)	75
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	532,475

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,211	2,502	$ 52,692	$ 21.06	1
2	Assistant Director of Nursing	1,960	2,197	44,944	20.46	2
3	Registered Nurses	52,802	56,712	1,097,461	19.35	3
4	Licensed Practical Nurses	7,290	8,575	136,946	15.97	4
5	Nurse Aides & Orderlies	75,625	84,430	678,823	8.04	5
6	Nurse Aide Trainees	1,700	1,714	12,460	7.27	6
7	Licensed Therapist	772	4,309	112,283	26.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,998	2,330	29,895	12.83	9
10	Activity Assistants	6,804	7,346	62,123	8.46	10
11	Social Service Workers	1,759	2,103	32,604	15.50	11
12	Dietician					12
13	Food Service Supervisor	2,176	2,369	46,703	19.71	13
14	Head Cook	3,391	4,336	49,734	11.47	14
15	Cook Helpers/Assistants	8,489	9,138	62,869	6.88	15
16	Dishwashers	11,111	12,102	96,947	8.01	16
17	Maintenance Workers	3,552	4,023	67,630	16.81	17
18	Housekeepers	16,249	19,299	165,391	8.57	18
19	Laundry	8,990	9,232	91,682	9.93	19
20	Administrator	1,984	2,100	72,724	34.63	20
21	Assistant Administrator	1,818	2,100	52,051	24.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,307	7,260	115,584	15.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,587	2,085	29,508	14.15	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	218,575	246,262	$ 3,111,054 *	$ 12.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	222	$ 10,380	1-3	35
36	Medical Director	9	900	9-3	36
37	Medical Records Consultant	24	574	10-3	37
38	Nurse Consultant	300	26,578	10-3	38
39	Pharmacist Consultant	24	1,011	10-3	39
40	Physical Therapy Consultant	128	7,723	10a-3	40
41	Occupational Therapy Consultant	212	13,380	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,889	11-3	44
45	Social Service Consultant	159	8,155	12-3	45
46	Other(specify) Psycho-Social	83	4,806	12-3	46
47	Dietary Agency	56	1,008	1-3	47
48					48
49	TOTAL (lines 35 - 48)	1,266	$ 77,404		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	11,814	271,990	10-3	52
53	TOTAL (lines 50 - 52)	11,814	$ 271,990		53

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jon Platakis	Administrator	0	$ 72,724
Lucille Wilcox	Asst. Administrator	0	52,051
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 124,775

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblattt	Accounting	$ 15,340
Mangum, Smietanka & Johnson	Legal	5,272
Management Data, Inc.	Computer Maint.	4,356
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 24,968

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	3,971
FICA Taxes	225,672
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	215,263
Health/Dental Insurance	403,318
Employee Physical Exams	3,374
Vaccines	509
Employee Recognition	1,862
TOTAL (agree to Schedule V, line 22, col.8)	$ 853,969

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	54,750
Health Care Worker Background Check	1,176
(Indicate # of checks performed 98)	
Yellow Page Advertising	288
Association Dues	5,968
Subscriptions	1,331
Licenses	440
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(288)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 63,665

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,444
Less: Out of State Seminar	(712)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,732

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number VALLEY HI NURSING HOME # 0004820 Report Period Beginning: 12/01/99 Ending: 11/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $4798**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.02**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,874** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **64,233**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,190**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% of In.**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Friedman, Eisenstein, Raemer, Schwartz** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not completed at this time**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw